SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

Filing at a Glance

Company: Great-West Life & Annuity Insurance Company

Product Name: J445rev and J355 APPS	SERFF Tr Num: GRWE-126592857	State: Arkansas
TOI: L08 Life - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 45472
Sub-TOI: L08.000 Life - Other	Co Tr Num: COLI APPS 4	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Alicia Uttley	Disposition Date: 04/22/2010
	Date Submitted: 04/20/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: J445rev and J355 APPS	Status of Filing in Domicile: Not Filed
Project Number:	Date Approved in Domicile:
Requested Filing Mode:	Domicile Status Comments: Exempt in state of domicile.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/22/2010	Explanation for Other Group Market Type:
	State Status Changed: 04/22/2010
Deemer Date:	Created By: Alicia Uttley
Submitted By: Alicia Uttley	Corresponding Filing Tracking Number:

Filing Description:

Application for Flexible Premium Adjustable Life Insurance, Form J445app4

Application for Flexible Premium Variable Universal Life Insurance, Form J355app4sa

Company and Contact

Filing Contact Information

Alicia Uttley, Compliance Analyst	alicia.uttley@gwl.com
8515 E. Orchard Rd.	303-737-6793 [Phone]

SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

8T2 303-737-5434 [FAX]

Greenwood Village , CO 80110

Filing Company Information

Great-West Life & Annuity Insurance Company	CoCode: 68322	State of Domicile: Colorado
8515 East Orchard Road	Group Code: 769	Company Type:
Greenwood Village, CO 80111	Group Name:	State ID Number:
(303) 737-3992 ext. [Phone]	FEIN Number: 84-0467907	

Filing Fees

Fee Required?	Yes
Fee Amount:	$100.00
Retaliatory?	No
Fee Explanation:	2 applications x 50.00 = 100.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Great-West Life & Annuity Insurance Company	$100.00	04/20/2010	35821805

SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/22/2010	04/22/2010

SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

Disposition

Disposition Date: 04/22/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Form	Application for Flexible Premium Adjustable Life Insuranc		Yes
Form	Application for Flexible Premium Variable Universal Life Insurance		Yes

SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

Form Schedule

Lead Form Number: J445app4

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	J445app4	Application/ Enrollment Form	Application for Flexible Premium Adjustable Life Insuranc	Initial		40.000	J445app4 Standard app.pdf
	J355app4sa	Application/ Enrollment Form	Application for Flexible Premium Variable Universal Life Insurance	Initial		40.000	J355app4sa.pdf

Great-West
LIFE & ANNUITY INSURANCE COMPANY

Application for Life Insurance
Great-West Life & Annuity Insurance Company
("The Company")

GENERAL INFORMATION

This page must be completed for all cases.

"Insured" whenever used in this application, means "the life proposed for insurance."

INSURED

Name: _____

Home Address: _____

_____

_____

Business Address: _____

_____

_____

Phone #: Day (___) _____ - _____

Evening (___) _____ - _____

Birth Date: ___/ ____/ _____SS #: _____ - _____ - _____

Place of Birth: _____

☐ See attached Schedule of Insureds

OWNER OF POLICY (IF OTHER THAN INSURED)

Name: _____

Business Address: _____

_____

_____

Phone #: Day (___) _____ - _____

Evening (___) _____ - _____

Relationship to Insured: _____

Owner's SS # or Tax ID #: _____

POLICY INFORMATION

Life Insurance or Premium Applied for:

Total Face Amount: $ _____

Base Face Amount: $ _____

Initial Periodic Premium Amount: $ _____

Mode of Payment: _____

Premium Payor (Owner, unless otherwise indicated):

Name: _____

Address: _____

_____

Death Benefit Option (Please check one):

Level Death ☐

Coverage Plus ☐

BENEFICIARY

Beneficiary: _____
(Please Print Full Name)

Relationship to Insured: _____

Contingent Beneficiary: _____
(Please Print Full Name)

Relationship to Insured: _____

REPLACEMENT

This page must be completed for all cases.

Do you have any existing insurance policies or annuity contracts? ..... ☐ **Yes** ☐ **No**
Will the policy applied for result in any insurance or annuity contract in this or any other Company being lapsed, surrendered, reduced, subjected to substantial borrowing, or changed to paid-up, extended term or automatic premium loan?. ..... ☐ **Yes** ☐ **No**

If yes, details: _____

Company Name: _____

Policy Number: _____

CITIZENSHIP STATUS

Is each individual named on this application a citizen of the United States? ..... ☐ **Yes** ☐ **No**

Please answer the following question for each insured that is a Non-U.S. Citizen:

Does the employee reside in the United States with a permanent resident visa? ..... ☐ **Yes** ☐ **No**

If No, please provide visa information for all Non-U.S. Citizens.

_____

_____

SIGNATURE

I declare and agree that: 1) All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 2) No information or answer to any question will be deemed communicated to or binding on Great-West Life & Annuity Insurance Company (The Company) unless set out in this application. 3) Only the president, a vice president or the secretary of The Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Any policy issued based on this application shall not take effect until delivered and the first premium paid to The Company, provided no change has taken place in the insurability of the Insured after the application, and any supplement to it is completed, and all proposed Insureds are still living.

I certify under penalty of perjury that the Social Security or tax identification number listed on this application is correct.

Signed at _____ this ____ day of _____ year _____
City and State

_____ **X** _____
Name of Proposed Insured (Please Print) Signature of Proposed Insured

X _____ **X** _____
Witness Signature of Owner

AGENT'S REPORT

1. Purpose of Insurance: ____________________________
2. Annual earned income before taxes: $ ______________
   Above based on: ☐ Insured's Statement ☐ Other
3. Does the applicant have existing life insurance policies or annuity contracts?............................ ☐ Yes ☐ No
4. Do you have reason to believe the life insurance applied for will replace any insurance or annuity with us or any other company? .... ☐ Yes ☐ No

If yes, details: ____________________________

Agent's Declaration - I certify that I have asked and have fully recorded the proposed Insured's answers to all questions in this application. I know nothing that is material to the insurability of this life that has not been recorded herein.

__________ X ____________________

Date Signature of Agent

Print Agent's Name: ____________________

Agent's License Number: ____________________

Phone #: (   )   - ____________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency/Institution: ____________________

Office: ____________________

Address: ____________________

Agent Share %: ____________________

This section must be completed for all simplified issue and fully underwritten cases.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART A

Name: _____ Occupation: _____

Total life insurance in force: $ _____ Driver's License #: _____ State: _____

1. Have you applied for insurance in the past 6 months? ☐ Yes ☐ No
2. Have you ever been refused life insurance? ☐ Yes ☐ No
3. During the past 12 months have you used tobacco or nicotine products in any form? ☐ Yes ☐ No

During the past three years have you:

4. Flown as a private pilot or do you contemplate flying as a student pilot or crew member? (If yes, please complete the aviation questionnaire.) ☐ Yes ☐ No
5. Participated in or do you contemplate participating in any sport such as racing (automobile, snowmobile, motorcycle, boat), scuba diving, hang gliding, mountain or rock climbing? (If yes, please complete the applicable sports questionnaire.) ☐ Yes ☐ No
6. **In the past three years**, have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? ☐ Yes ☐ No
7. **In the past 10 years**, have you been medically advised that you have, or received any type of treatment for positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

If you answered yes to questions 1-7, provide details: _____

INSURED'S PERSONAL AND MEDICAL INFORMATION PART B

Height: _____ Weight: _____

1. Do you have a personal physician? If yes, please provide name and address: ☐ Yes ☐ No
2. Please provide date last seen, reason seen and results: _____
3. Have any members of your immediate family died before age 60? ☐ Yes ☐ No
4. Are you currently taking any medication(s)? ☐ Yes ☐ No
5. Have you ever been hospitalized? (If yes, give details below including date(s) and reason(s). ☐ Yes ☐ No

Within the past 10 years, has a member of the medical profession diagnosed you as having or treated you for any of the following:

6. Any permanent disease or disorder, including those requiring medical or surgical intervention of the heart, lungs, liver, kidneys, gastrointestinal system? ☐ Yes ☐ No
7. Elevated blood pressure, stroke, paralysis, or any chronic or progressive disease or disorder of the brain, spinal cord or central nervous system? ☐ Yes ☐ No
8. Blood disorders including chronic anemia? ☐ Yes ☐ No
9. Diabetes, cancer or malignancy? ☐ Yes ☐ No
10. Treatment for alcohol or drug use, or have you been medically advised to do so? ☐ Yes ☐ No
11. Any counseling or treatment for mental, nervous or emotional disorders? ☐ Yes ☐ No
12. Any physical impairments or diseases not listed above? ☐ Yes ☐ No

If you answered yes to questions 1-12, provide details: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

I have received and read the Notice of Insurance Information Practices and Notice Regarding Medical Information (MIB). Great-West Life & Annuity Insurance Company (the Company), its reinsurers and their authorized representatives, may obtain medical and other information in order to evaluate my application for life insurance. The Medical Information Bureau, Inc., consumer reporting agency, state motor vehicle department or insurance company who possesses medical or other information about my health or me may furnish such information to the Company upon presenting this authorization or a photocopy. The Company may make a brief report regarding me or my health to the MIB or to other Bureau Member companies to whom I have applied or may apply and have authorized to receive such information. I consent to a consumer report containing personal information that may be requested in connection with my application. This authorization is valid from the date signed for a period of 2 1/2 years. I have read this authorization and understand I have the right to receive a copy.

Signed at _____ this ___ day of _____ year _____
City and State

_____ **X** _____
Name of Proposed Insured (Please Print) Signature of Proposed Insured

X _____ **X** _____
Witness Signature of Owner

FRAUD WARNINGS

[California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia, Maine, Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Massachusetts, Oregon and Vermont: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and subjects such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your business associates, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Inquiries on the above notices should be addressed to:

[Great-West Life & Annuity Insurance Company
Department 690, P.O. Box 1700
Denver, CO 80201]

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Recording Act. The address of the Bureau's information office is:

[MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734
Phone: 866-692-6901 (TTY 866-346-3642)]

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS REQUIRED OF ALL LIFE INSURANCE PROVIDERS. BE ASSURED THAT GREAT-WEST'S BUSINESS PRACTICES MEET THE HIGHEST INDUSTRY STANDARDS.

Please keep this form for your records

Great-West
LIFE & ANNUITY INSURANCE COMPANY

Application for an Individual Flexible Premium Variable Universal Life Insurance Policy to
Great-West Life & Annuity Insurance Company
("the Company")

This page must be completed for all cases.

GENERAL INFORMATION

"Insured" whenever used in this application, means "the life proposed for insurance."

INSURED

Name _____

Home Address _____

_____

_____

Business Address _____

_____

_____

Phone #: Day (____) _____ - _____

Evening (____) _____ - _____

Birth Date: ____ /____ /____ SS # ____-____-____

Place of Birth _____

OWNER OF POLICY (IF OTHER THAN INSURED)

Name _____

Business Address _____

_____

_____

Phone #: Day (____) _____ - _____

Evening (____) _____ - _____

Relationship to Insured _____

Owner's SS # or Tax ID # _____

☐ See attached Schedule of Insureds

Owner is: ***(Please choose one of the following)***

a. ☐ **The Employer**

b. ☐ **A Trust created by the Employer**

c. ☐ **A Trust created by the Insured**

d. ☐ **The Insured**

e. ☐ **Other** _____

POLICY INFORMATION

Life Insurance or Premium Applied for:

Total Face Amount $ _____

Base Face Amount $_____

Rider Face Amount $_____

Premium $_____

Mode of Payment_____

Premium Payor (Owner, unless otherwise indicated)

Name _____

Address _____

_____

Death Benefit Option (Please check one):

Level Death ☐
Coverage Plus ☐

Transfer Provisions (Optional):

Dollar Cost Averaging ☐
-OR-
Rebalancer Option ☐

BENEFICIARY

Please choose one of the following:

☐ **Employer** ☐ **Trust created by the Employer** ☐ **Trust created by the Insured**

If the employer is the beneficiary, the employer certifies, represents and warrants that:

a. The employer has a lawful and substantial economic interest in the life, health and safety of each proposed insured;

b. The services of each such proposed insured are such that the employer expects to realize either:

- A substantial monetary gain through the continued life of the proposed insured; or
- A substantial monetary loss in the event of the proposed insured's death.

c. Per the requirements set forth in I.R.C.§101(j), the insured:

- had "compensation" in excess of the IRC § 414(q) limitation, as adjusted annually for inflation; or
- is among the highest paid 35% of all employees, determined in accordance with the rules of IRC § 105(h); or
- is an owner of 5% or more of the employer at any time during the year (or was in the preceding year); or
- is among the top 5 highest paid officers of the company

Additionally, in order to comply with IRC§101(j), employers must obtain positive written consent from employees that the employer may insure their life. This consent must disclose that the corporation will reside as beneficiary of the policy death benefit and the maximum amount of insurance that may be issued on their life. This information must be obtained PRIOR to the issue of any policy. Failure to do so may result in adverse tax consequences.

Please sign below stating you have read and understand the above conditions.

_____ _____
Employer Name (Please Print) **Title**

X _____ _____
Employer Signature **Date**

CITIZENSHIP STATUS

Is each individual named on this application a citizen of the United States? ..... ☐ **Yes** ☐ **No**

Please answer the following question for each insured that is a Non-U.S. Citizen:

Does the employee reside in the United States with a permanent resident visa?..... ☐ **Yes** ☐ **No**

If No, please provide visa information for all Non-U.S. Citizens.

_____

_____

REPLACEMENT

Do you have any existing insurance policies or annuity contracts? ..... ☐ **Yes** ☐ **No**

Will the policy applied for result in any insurance or annuity contract in this or any other Company being lapsed, surrendered, reduced, subjected to substantial borrowing, or changed to paid-up, extended term or automatic premium loan? ..... ☐ **Yes** ☐ **No**

If yes, details: _____

Company Name: _____

Policy No.: _____

COMPLIANCE INFORMATION

The Securities Exchange Act of 1934 requires that we have reasonable grounds to believe, based upon the information provided by you, that your selections are suitable given your objectives and financial situation. Please complete the following relating to the suitability of your investment choices.

Do you understand that, under this policy, all payments and values including cash values and the death benefit are based on the investment experience of the Investment Divisions and are variable? ..... ☐ **Yes** ☐ **No**

Do you believe that this policy will meet your objectives and anticipated financial needs?..... ☐ **Yes** ☐ **No**

I have received a copy of the current product prospectus for this Flexible Premium Variable Universal Life Policy. ..... ☐ **Yes** ☐ **No**

INVESTMENT ALLOCATION

You may choose to allocate your premium payments to one or more of the investment options listed below. Please indicate your selections in *whole percentages*.

Note: During the Free Look Period, premium payments will be allocated to the investment option(s) you choose below. If you return your policy during the Free Look Period, the policy will then be deemed void from the start and we will refund the Policy Value Account. Please refer to the prospectus for details. If you do not indicate your allocations below or if they do not total 100 percent, your application will not be processed.

Fixed Option		**Maxim Series, Inc.**	
%	Fixed Account Option	%	Maxim Ariel Small-Cap Value Portfolio
[AIM Variable Insurance Fund (Series I Shares)		%	Maxim MFS International Value Portfolio
%	AIM V.I. Global Real Estate	%	Maxim Bond Index Portfolio
%	AIM V.I. International Growth Fund	%	Maxim Federated Bond
%	AIM V.I. Mid Cap Core Equity	%	Maxim Global Bond Portfolio
Alger Portfolios (Class I-2 Shares)		%	Maxim INVESCO ADR Portfolio
%	Alger Small Cap Growth Portfolio	%	Maxim Janus Large Cap Growth Portfolio
American Century Variable Portfolios, Inc. (Class I Shares)		%	Maxim Loomis Sayles Bond Portfolio
%	American Century VP Value Fund	%	Maxim Loomis Sayles Small-Cap Portfolio
%	American Century VP Vista^{SM} Funds	%	Maxim Money Market Portfolio
American Funds Insurance Series (Class 2)		%	Maxim Short Duration Bond Portfolio
%	American Funds Global Small Capitalization	%	Maxim T. Rowe Price Equity/Income Portfolio
%	American Funds Growth	%	Maxim T. Rowe Price MidCap Growth Portfolio
%	American Funds International	%	Maxim U.S. Government Securities Portfolio
%	American Funds New World	**Maxim Lifetime Asset Allocation Portfolios (Class T)**	
Columbia Variable Series (Class A)		%	Maxim Lifetime 2015 I
%	Columbia Mid Cap Value	%	Maxim Lifetime 2025 I
%	Columbia Small Cap Value	%	Maxim Lifetime 2035 I
Davis Variable Account Fund, Inc.		%	Maxim Lifetime 2045 I
%	Davis Financial Portfolio	%	Maxim Lifetime 2055 I
%	Davis Value Portfolio	**Maxim Profile Portfolios**	
Dreyfus Stock Index Fund, Inc. (Initial Shares)		%	Maxim Aggressive Profile I Portfolio
%	Dreyfus Stock Index Fund	%	Maxim Conservative Profile I Portfolio
Dreyfus Variable Investment Fund (Initial Shares)		%	Maxim Moderately Aggressive Profile I Portfolio
%	Dreyfus VIF International Equity Portfolio	%	Maxim Moderately Conservative Profile I Portfolio
DWS Investments VIT (A Shares)		%	Maxim Moderate Profile I Portfolio
%	DWS Small Cap Index VIP	**Neuberger Berman Advisors Management Trust**	
DWS Variable Series I (A Shares)		%	Neuberger Berman AMT Regency (I)
%	DWS Global Opportunities VIP	%	Neuberger Berman AMT Socially Responsive (I)
DWS Variable Series II (A Shares)		**PIMCO VIT (Administrative Shares)**	
%	DWS Alternative Asset Allocation Plus VIP	%	PIMCO VIT High Yield Portfolio
%	DWS Blue Chip VIP	%	PIMCO VIT Low Duration Portfolio
%	DWS Dreman Small Mid Cap Value VIP	%	PIMCO VIT Real Return Portfolio
%	DWS High Income VIP	%	PIMCO VIT Total Return Portfolio
Fidelity Variable Insurance Products VIP (Svc 2 Shares)		**PUTNAM Variable Trust** (IA Shares)	
%	Fidelity VIP Contrafund® Portfolio	%	Putnam VT Equity Income
%	Fidelity VIP Mid Cap Portfolio	%	Putnam VT International New Opportunities
Janus Aspen Series (Institutional Shares)		%	Putnam VT High Yield
%	Janus Aspen Balanced Portfolio	%	Putnam VT MidCap Value
%	Janus Aspen Flexible Bond Portfolio	**Royce Capital Fund** (Service Class Shares)	
%	Janus Aspen Forty Portfolio	%	Royce Micro-Cap
%	Janus Aspen Global Life Sciences Portfolio	%	Royce Small-Cap
%	Janus Aspen Global Technology	**Van Eck Global**	
%	Janus Aspen Series Overseas Portfolio	%	Van Eck Worldwide Hard Assets Fund]
Total = 100%			

SIGNATURE

I declare and agree that:

All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 1) No Information or answer to any question will be deemed communicated to or binding on the Company unless set out in this application. 2) Only the president, a vice president or the secretary of the Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Any policy issued based on this application shall not take effect until delivered and the first premium paid to The Company, provided no change has taken place in the insurability of the Insured after the application, and any supplement to it is completed, and all proposed Insured's are still living.

I understand that I am applying for an Individual Flexible Premium Variable Universal Life Insurance Policy, form J355, issued by Great-West Life & Annuity Insurance Company. I declare that all statements made on this application are true to the best of my knowledge and belief. I believe the policy is suitable for my insurance needs. **I understand that all amounts are based on the investment experience of the investment divisions and are not guaranteed as to amount; they are variable and may increase or decrease accordingly.** I hereby direct that my telephone instructions to the Company be honored for transactions unless otherwise notified by me in writing. I understand that telephone calls may be recorded to monitor the quality of service I receive and to verify policy transaction information. **I certify under penalty of perjury that the Social Security or tax identification number listed on this application is correct. The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.**

Signed at _____ this _____ day of _____ year _____
City and State

_____ **X** _____
Name of Proposed Insured (Please Print) Signature of Proposed Insured

X _____ **X** _____
Witness Signature of Owner

STATEMENT OF ADDITIONAL INFORMATION

Check here if you'd like a copy of the Statement of Additional Information to the prospectus. ☐

AGENT'S REPORT

1. Purpose of Insurance ______________________
2. Annual earned income before taxes $ __________
   Above based on: ☐ Insured's Statement ☐ Other
3. Does the applicant have existing life insurance policies or annuity contracts? .... ☐ Yes ☐ No
4. Do you have reason to believe the life insurance applied for will replace any insurance or annuity with us or any other company? .... ☐ Yes ☐ No

If yes, details: ______________________________

____

____

____

____

____

Agent's Declaration - I certify that I have asked and have fully recorded the proposed Insured's answers to all questions in this application. I know nothing that is material to the insurability of this life that has not been recorded herein.

__________ **X** ____________________

Date Signature of Agent

Print Agent's Name: ____________________

Agent's Number: ____________________

Phone #: (   )   - ____________________

Agency: ____________________

Broker Dealer: ____________________

Office: ____________________

Address: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency: ____________________

Broker Dealer: ____________________

Office: ____________________

Address: ____________________

____

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency: ____________________

Broker Dealer: ____________________

Office: ____________________

Address: ____________________

____

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

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Office: ____________________

Address: ____________________

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Agent Name: ____________________

Agent Signature: ____________________

Agency: ____________________

Broker Dealer: ____________________

Office: ____________________

Address: ____________________

____

Agent Share %: ____________________

Agent Name: ____________________

Agent Signature: ____________________

Agency: ____________________

Broker Dealer: ____________________

Office: ____________________

Address: ____________________

____

Agent Share %: ____________________

FRAUD WARNINGS

[California: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia, Maine, Tennessee and Virginia: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Massachusetts, Oregon and Vermont: Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

All Other States: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.]

This section must be completed for all simplified issue and fully underwritten cases.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART I

Name: _____ Occupation _____

Total life insurance in force: $_____ Driver's License # _____ State: _____

1. Have you applied for insurance in the past 6 months? ☐ Yes ☐ No
2. Have you ever been refused life insurance? ☐ Yes ☐ No
3. During the past 12 months have you used tobacco or nicotine products in any form? ☐ Yes ☐ No

During the past three years have you:

4. Flown as a private pilot or do you contemplate flying as a student pilot or crew member? (If yes, please complete the aviation questionnaire.) ☐ Yes ☐ No
5. Participated in or do you contemplate participating in any hazardous sport such as racing (automobile, snowmobile, motorcycle, boat), scuba diving, hang gliding, mountain or rock climbing? (If yes, please complete the hazardous sports questionnaire.) ☐ Yes ☐ No
6. **In the past three years,** have you been charged with driving under the influence of alcohol or drugs (DUI), or have you had your driver's license suspended or revoked? ☐ Yes ☐ No
7. **In the past 10 years,** have you been medically advised that you have, or received any type of treatment for a positive test for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No

If you answered yes to questions 1-7, provide details: _____

This section must be completed for simplified issue only.

INSURED'S PERSONAL AND MEDICAL INFORMATION PART II

Height: _____ Weight: _____

1. Do you have a personal physician? If yes, please provide name and address: ☐ Yes ☐ No
2. Please provide date last seen, reason seen and results: _____
3. Have any members of your immediate family died before age 60? ☐ Yes ☐ No
4. Are you currently taking any medication(s)? ☐ Yes ☐ No
5. Have you ever been hospitalized? (If yes, give details below including date(s) and reason(s)) ☐ Yes ☐ No

Within the past 10 years, has a member of the medical profession diagnosed you as having or treated you for any of the following:

6. Any permanent disease or disorder, including those requiring medical or surgical intervention of the heart, lungs, liver, kidneys, gastrointestinal system? ☐ Yes ☐ No
7. Elevated blood pressure, stroke, paralysis, or any chronic or progressive disease or disorder of the brain, spinal cord or central nervous system? ☐ Yes ☐ No
8. Blood disorders including chronic anemia? ☐ Yes ☐ No
9. Diabetes, cancer or malignancy? ☐ Yes ☐ No
10. Treatment for alcohol or drug use, or have you been medically advised to do so? ☐ Yes ☐ No
11. Any counseling or treatment for mental, nervous or emotional disorders? ☐ Yes ☐ No
12. Any physical impairments or diseases not listed above? ☐ Yes ☐ No

If you answered yes to questions 1-12, provide details: _____

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

Great-West Life & Annuity Insurance Company (the "Company"), its reinsurers, insurance support organizations, and their authorized representative, may obtain medical and other information in order to evaluate my application for life insurance. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, the Medical Information Bureau, Inc., my employer and consumer reporting agency, credit reporting agency or insurance company who possesses information of care, treatment or advice of me may furnish such information to the Company upon presenting this authorization or a photocopy. This authorization includes information about drugs, alcoholism and mental illness. The Company or its reinsurers may make a brief report regarding me to other companies to whom I have applied or may apply. This authorization will be valid from the date signed for a period of two and one-half years. I have read this authorization and understand I have the right to receive a copy. I have received the Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau. I consent to a consumer report containing personal or credit information or both that may be requested in connection with my application.

All statements and answers to questions made in this application and any supplement to it are true and complete to the best of my knowledge and belief. The information I have provided will be taken into consideration for and will serve as the basis of any contract of insurance based on this application. 1) No Information or answer to any question will be deemed communicated to or binding on the Company unless set out in this application. 2) Only the president, a vice president or the secretary of the Company is authorized to change or waive any terms of this application or any contract of insurance issued.

Signed at _____ this _____ day of _____ year _____
City and State

_____ **X** _____
Name of Proposed Insured (Please Print) Signature of Proposed Insured

X _____ **X** _____
Witness Signature of Owner

Notice of Insurance Information Practices and Notice Regarding Medical Information Bureau

This is to inform you that, as part of our procedure for processing your application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your business associates, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, financial information and mode of living. You have the right to make a written request within a reasonable period of time to receive additional detailed information about the nature and scope of this investigation. You have the right to access information upon written request. You may request correction, amendment or deletion of any information which you believe to be inaccurate.

In connection with your application for insurance you may receive a telephone call from an authorized person to obtain some personal and financial information. You may be assured that the information is considered confidential and will be used to assess your eligibility for insurance. The interview normally takes from five to ten minutes and will be conducted at a time convenient for you. In the event you are not in when the interviewer calls, the interviewer will leave his or her name and telephone number so that you can return the call at no charge to you and supply the necessary information.

Inquiries on the above notices should be addressed to:

[Great-West Life & Annuity Insurance Company
Department 690, P.O. Box 1700
Denver, CO 80201]

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers, may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information it may have in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Recording Act. The address of the Bureau's information office is:

[MIB, Inc.
50 Braintree Hill Park, Suite 400
Braintree, MA 02184-8734
Phone: 866-692-6901 (TTY 866-346-3642)]

The Company, or its reinsurers, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

THIS STANDARD DISCLOSURE IS REQUIRED OF ALL LIFE INSURANCE PROVIDERS. BE ASSURED THAT GREAT-WEST'S BUSINESS PRACTICES MEET THE HIGHEST INDUSTRY STANDARDS.

SERFF Tracking Number:	*GRWE-126592857*	*State:*	*Arkansas*
Filing Company:	*Great-West Life & Annuity Insurance Company*	*State Tracking Number:*	*45472*
Company Tracking Number:	*COLI APPS 4*		
TOI:	*L08 Life - Other*	*Sub-TOI:*	*L08.000 Life - Other*
Product Name:	*J445rev and J355 APPS*		
Project Name/Number:	*J445rev and J355 APPS/*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
ar compliance cert.pdf

Item Status: **Status Date:**

Bypassed - Item: Application
Bypass Reason: Not applicable. Application filing.
Comments:

Item Status: **Status Date:**

Satisfied - Item: Cover Letter
Comments:
Attachment:
AR Letter.pdf

STATE OF ARKANSAS
INSURANCE DEPARTMENT

CERTIFICATE OF COMPLIANCE

RE: **Application for Flexible Premium Adjustable Life Insurance, Form J445app4**
Application for Flexible Premium Variable Universal Life Insurance, Form J355app4sa

We hereby certify that the guidelines established in Arkansas Rule and Regulation 19 have been reviewed and the forms designated above comply with these guidelines.

We hereby certify that the above policy forms meet the minimum Flesch Reading Ease Test score requirements.

Great-West Life & Annuity Insurance Company

Susan Gile
Vice President, Individual Markets Operation

April 20, 2010
Date

Great-West
LIFE & ANNUITY INSURANCE COMPANY

8515 East Orchard Road
Greenwood Village, CO 80111 Tel. (303) 737-3000
Address mail to: P.O. Box 1700, Denver, CO 80201
www.gwla.com

April 19, 2010

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

NAIC #769-68322

RE: **Individual Life Insurance Submission**
Application for Flexible Premium Adjustable Life Insurance, Form J445app4
Application for Flexible Premium Variable Universal Life Insurance, Form J355app4sa

Enclosed for your review and approval are the above referenced forms and pertinent documentation. These forms are new, upon approval and implementation will replace previously approved applications.

New Application	Application being Replaced	Date application was previously approved	DOI/SERFF filing #	Policy Application used to apply for	Date Policy was previously approved	DOI/SERFF filing #
J445app4	J445app3	5/22/06	USPH-6PQT9R895	J445rev-cso	6/4/08	GRWE-125682071
J355app4	J355app3sa	10/17/06	USPH-6U9Q8H916	J355-CSO	6/9/08	GRWE-125682163

The changes from the previously approved applications are listed below:

- Removed Foreign Travel Questions.
- Added Home Address to Insured
- Added Business Address to Owner
- Removed Rider Face Amount
- Changed text under Beneficiary section to more closely mirror language in IRC § 101(j).
- Added additional lines for multiple agents.

Each of these applications contains a score in excess of 40 using the Flesch Reading Ease Test.

We are exempt from filing in Colorado, our state of domicile, pursuant to Regulation 5-92. Colorado requires a fee to be paid each February 28th based on our Company's direct written premium. If appropriate, a retaliatory fee has been paid in your state in conjunction with your annual premium tax return.

We reserve the right at any time to make non-material changes to these forms, including (but not limited to) paper stock, type face (but not font size) and page layout made necessary by unavoidable changes.

To the best of our knowledge, this submission complies with your state laws and regulations. We look forward to your approval. Should you have any questions, please call me on our toll-free number, (800) 537-2033, ext 75829 or via email at Tanya.gonzales@gwl.com

Sincerely,

Tanya D. Gonzales
Manager, Individual Markets